the taking away of the Medicaid entitlement. Fight to end the monstrous cuts in the HUD programs for low income housing. Fight to support the retention of adequate wages and pensions for the military, Federal workers and other public service workers.

Fight to increase the minimum wage. The Republican majority said they will not entertain any dialog on increasing the minimum wage. One hundred American economists have said we need an increase in the minimum wage. The only way you can have workers keep pace with what has happened is to increase the minimum wage. All we are proposing in the Gephardt bill, which I am a cosponsor of, is a measly 45-cent increase in two steps, a 90-cent increase in the minimum wage.

The Republican majority says they will not entertain any discussions of any increase in the minimum wage.

So we need to fight to increase the minimum wage. We need to fight to guarantee the right to organize unions in the worker replacement provisions. To end striker replacement, we have to first support President Clinton's Executive order. We need to fight to maintain health and safety conditions in the workplace. There has been a fight on the Occupational Safety and Health Administration [OSHA]. We need to fight that.

We need to fight for cuts in the defense budget, those cuts that will downsize the budget and generate the money to fund the programs needed. We need to fight for an increase in foreign aid to Africa, Caribbean, Haiti. Haiti was one of our proudest moments in our foreign policy. The anniversary of the liberation of Haiti will take place shortly. We should take note of the fact it was a shining hour, a great moment, for American foreign policy.

We need to fight for an increase in the funds for youth crime prevention program. The majority has eliminated this program. We need to fight for an increase in those programs and a decrease in the prison funds to build prisons.

We need to fight and unite with the caring majority for the retention of Social Security as it is now. They are chipping away at Social Security. Do not believe what you hear. Stop moving the age requirement back. Stop tampering with the COLA's. This is an agenda for the caring majority. You need to move on an agenda that is focused.

I have a timetable. You need to have actions in your localities, in your States. You need to do things. Americans are not spectators. We are not put in that spectator role. Actions at the local level, make allies, all races, all sexes, all religions. And finally we need an action in Washington.

The whole culmination of this activity should take place in Washington. Washington is the place, Washington is the key. What happens here sends out signals. It determines the way things are going to go in the States and in the cities. Washington does not provide all the money for our cities and local government, but they set the tone. So, therefore, at some time on this agenda, the climax has to be the caring majority with its agenda has to come to Washington in millions. The caring majority has to come.

I propose next spring, the anniversary of Tiananmen Square in China, why don't we come together and work toward it between now and next June? Tiananmen Square in China took place in the first week of June. Tiananmen Square I offer because it is so important to note the fact that a totalitarian government of China could not resist, could not stop the flow of information out from Tiananmen Square to the rest of the world. When you get that many people together with determination, they built statutes of liberty, the media was there. The media tends to try to ignore the caring majority agenda. You cannot get the same exposure for the caring majority agenda that you get for the Republican health care plan.

So a Tiananmen Square type operation, have a million people come together on the mall. You have an agenda. There is no question why you are there. Come together to confront the Congress, confront the White House. What we need most of all is direction for our Government. Let us plan to do it. You are not spectators in America. You have the right to get up and move. Let us use our right and let us make certain that the remaking of America does not take place while we are sitting on the sidelines. Troops, get ready. The march you make will be to save your own soul and your own nation.

THE TRUTH ON MEDICARE

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from Ohio [Mr. HOKE] is recognized for 60 minutes as the designee of the majority leader.

Mr. HOKE. Mr. Speaker, we have an off day today, and I thought that I would take advantage of the opportunity to both respond to some of the charges made with respect to Medicare and then probably, more importantly, talk about exactly what it is that we are going to me marking up next week with respect to a really very, very needed reform of the Medicare program in America.

I wanted to talk particularly to the senior citizens today, Mr. Speaker, because I know that there is a great deal of anxiety and concern and some confusion as well. My gosh, if I were watching this debate on a day-to-day basis at home and trying to ferret out the truth from the confusion, I think it would be a tremendous challenge.

So what I would like to do is, first of all, think about the one charge that has been raised on a daily basis with respect to Medicare by the minority party, and then go into the actual details of what we are going to do.

What we have heard here on the floor on a regular basis is that Medicare is going to be slashed by $270 billion over the next 7 years in order to pay for tax cuts for the rich. I would like to take that apart on a piece-by-piece basis and show that it is completely untrue. I would like to do it from the back end, because I think that the tax cuts for the rich is probably the kind of class warfare that turns one off, but has a kind of a hook. It is sort of like pornography. You know, people are offended by it, and they recognize that they are hearing something that is wrong and that there is something fundamentally wrong about it; but, at the same time, there is something attractive about it, because it seems as though there is a hook there.

Well, the hook of class warfare is it is an ugly hook, and it is a hook that basically says we should not aspire. It assumes that people do not want to aspire to the American dream and they do not want to aspire to be able to actually improve their position materially for themselves and for their families.

The fact is that with respect to the tax cut, it has absolutely nothing to do, nothing whatsoever, to do with Medicare. It has nothing to do with anything other than a tax cut. And the Medicare trust fund, which is the part A trust fund, is not affected by whether we raise taxes or whether we lower taxes.

The Medicare trust fund is actually funded by the 1.45 percent payroll tax that comes from people who have earned income, workers, employees, and employers. Anybody that has earned income gets taxed at 1.45 percent, the worker, the employee, plus another 1.45 percent on the employer. And there is no limit on what that amount of money can be. There used to be a cap. You know, the first $60,000 or so of income is subject to the Social Security tax, and that that is what funds Social Security. But there is a ceiling on that, and the ceiling is the first $60,000. There is no ceiling on the amount of money that is taxed for Medicare at this 1.45 percent amount.

All of that money goes into part A of the Medicare trust fund and it is part A of the Medicare trust fund, it is that HI, health insurance trust fund, that is going bankrupt.

I have some charts here. The reason we know it is going bankrupt is that the trustees of the trust fund are required by law to make a report to the President on an annual basis, to talk about and describe the actual status of the fund, of the trust fund themselves.

By the way, this is not a partisan group or political group. If it is political, it is partisan in terms of being members of the party of the President, whoever the President happens to be. In this case three of the members, three of the trustees are Robert Reich, the Secretary of Labor, Donna Shalala,

the Secretary of Health and Human Services, and Bob Rubin, the Secretary of the Treasury. In addition, there is the Commissioner of the Social Security Administration and two private sector trustees. They all sign this report. They say, and this was dated April 3, 1995, the fund is projected to be exhausted in 2001. That is under the worst case scenario. Under the middle case scenario it is projected to be exhausted in 2002.

Now, the money that goes into this fund, and this is the important point, the only money that goes into that fund comes from the 1.45 percent payroll tax that is paid by workers, working people in this country. That is where the part A trust fund revenues come from. They do not come from tax revenue.

We could have an increase and make a marginal rate of 70 percent, and not one more dollar would go into part A of the Medicare trust fund. That is what is going bankrupt.

You can see right here the trust fund reserves. Right now there is actually about $150 billion in the trust fund. This is a chart that is reproduced from that same April 3, 1995, annual report of the health insurance trustees. By the way, anybody that wants a copy of that report, they are available from your congressional office. If you simply call the Capitol switchboard and ask for your Congressman and talk to their legislative assistant that deals with health care, ask them to send you a copy of the trustee's report on the HI trust fund dated April 3, 1995. There is a 14-page summary of it. If you call 202–225–3121 and ask for a copy of it, they will give you the full copy. It is well written, plainly written, and it is not a partisan document. It simply describes what is going on with this program.

Anyway, this is a chart reproduced from that report. It shows you very clearly that starting in 1996, the fund actually is paying out more than it takes in. In other words, it is paying out more to hospitals and doctors than it is taking in in revenue in that 1.45-percent amount. As you can see, you get to zero in about the year 2002, where there is nothing left whatsoever in the fund. Once there is no money in the fund, there is no money to pay. Without a change in the law or a change in the tax rate, that money is exhausted, and it is all over for the payments.

That is why the trustees in their report are so strong and so clear about saying Congress has got to act. Congress has got to do something to protect this fund if we are going to have Medicare in the future. And there has got to be a resolution brought, or we are going to be completely without health care for senior citizens with respect to the part A.

So that is what the point is. The point is that the tax issue, this issue of raising or lowering taxes for the rich has absolutely nothing to do with Medicare part A. Not one penny.

Now, let us look at the charge with respect to this idea that the cut goes to the rich. What did we do in August 1993 in this body? I was a freshman Congressman at the time and I remember it vividly. What we did is we passed the greatest, the largest tax increase in the history of our country. One of the things that we did in that tax increase is that we increased the highest marginal rate, first of all to 36 percent, and they we put a 10 percent ''millionaire's surcharge'' on top of that, so that people that have income of more than $1 million would have an additional surtax of 10 percent. So the top marginal rate right now in the United States is 39.6 percent.

Well, there are a lot of people who think that that is bad policy. There are a lot of economists that will tell you when you increase the marginal tax rate at the top, you are not going to actually increase revenue. What you will find is people's behaviors will change. I think that those people are correct.

But the fact is that that change in the law was made in August 1993, and it is still the law, and this Congress has not done anything and does not intend to do anything and is not going to do anything to change that law, to repeal that, to come back and repeal that 10-percent surtax that was added on.

Now, if this Congress, if the majority party, the Republican Party, wanted in fact to give a tax cut to the rich, would not the first place to go be to repeal the add-on, that surcharge that was made into law in August 1993? It seems to me that is where we would go. But there has been no talk of that. Of course, there has been no talk of that.

But what we have done is created a tax break to give relief to middle-income families. Over 75 percent of the tax relief in the tax cut package that is part of the Contract With America goes to families making less than $75,000 per year. The tax break goes to families, and it goes to working families. It goes to that group of people in America who are shouldering the greatest amount of the tax burden, and it tries to bring some tax equity so it is easier to raise a family in the United States.

Let us go to the first part of the catechism that you hear so frequently in the Chamber, and that is that we are slashing Medicare by $270 billion.

Well, how is it possible? The real problem in Washington, and probably the greatest change that we made in this Congress, the most important change and one that rarely gets talked about because it is a subtle change, but it will have more to do with giving the truth, telling the truth to the American people about the money that is spent in the U.S. Congress, their tax dollars, is this change away from what is known as baseline budgeting.

Basically baseline budgeting is a kind of phony accounting system that is used nowhere in this country except right here with the Federal Government. What it does is it says that we predict that we should be spending *x* number of dollars in 1996 while we are spending *a* number of dollars in 1995. We think that in 1996 we will probably be spending this amount of money, and because that is what we think we should be spending, then if we spend less than that, that is a cut.

Let us make it in real terms. If we spent in 1995 $175 billion on a program, and the Congressional Budget Office says that they think we are going to spend $200 billion in the program in 1996, but the Congress says well, no, we don't think we need to spend $200 billion, we think we can do the same job or a better job for $185 billion, well, according to the CBO, that used to be, before we changed the law on this, that used to be known as a $15 billion cut, even though we were spending $25 billion more in 1996 than we spent in 1995.

Nowhere else in America, nowhere else in America, is that a cut, only right here in Washington. The problem with it is that it confuses the public. It confuses the voters and makes it very, very difficult for voters to make real choices about whom they want to represent them in the U.S. Congress or the U.S. Senate or in the White House.

What we have done this year, the very first day of the Congress, and then we memorialized it again in some other budget language that came out with the first budget resolution, is we have changed the law, so that now when we talk about spending for 1996 and the numbers that are in this budget, the numbers that are in this 7-year budget that go out to 2002 are not based on predictions of what we should or could or might be spending in the future.

They are based on what we spent in 1995, the same way that you do your accounting at home, the same way that companies all over this country do their accounting. It means that, if you spent $150 a month, if a person in a family spent $150 a month on utilities in 1995, and they spend $160 a month on utilities in 1996, that is a $10-per-month increase. That is how much it is. And we are going to use the same language right here in the U.S. Congress that everybody else is using in this country.

Well, let us see what that means. What it means is that we, under the Medicare proposal that will be debated on the floor next week, that has been a subject of many, many hearings in the past 2 years actually, and over this summer we will be spending twice as much, twice as much on Medicare in the next 7 years than we spent in the previous 7 years.

To make it more close to home, we will be spending $4,800, we are spending right now $4,800 per beneficiary per year right now. That is going to $6,700 per beneficiary in the year 2002. By the way, does it take into account the predictions on demographic changes in terms of new enrollees? Because we

know that more and more we are having increasing enrollment in Medicare as we have an aging of our population.

So what we know is we are going from $4,800 per beneficiary per year, that is about $400 per month, up to $6,700 per beneficiary per year in the year 2002.

Now, if that is a cut, where is the cut? How is that a cut? Could somebody please explain to me how that could possibly be called a cut? It is about a 35-percent increase in spending per beneficiary.

All right. So let us start with those basics. We have $4,800 a year going up to $6,700. Obviously we are increasing the amount of money to be spent on Medicare. The real question is, A, can we provide health care for every senior citizen in this country over the age of 65 for that amount of money? And, B, can we do maybe a better job than the traditional fee-for-service medicine which has been the hallmark and only way we have distributed Medicare up until very, very recently?

We have done some pilot programs with managed care models around the country now with Medicare. But up until recently, the only kind of medical services that were available under Medicare was traditional fee for service.

I happen to think that traditional fee for service is a heck of a good way to deliver medical services. But there is a problem when nobody is minding the cost factor, when nobody is paying attention to how much it costs. Let us face it: If the Government is paying for all of it, then the patient does not particularly care about it. If the Government is not being vigilant about what things are costing and whether or not the bills they are getting are real bills and ought to be paid, then you have got terrible problems. That is the situation that we have come into with respect to Medicare now.

In fact, we found out from the Director of the Congressional Budget Office at hearings in 1994 that they believe 15 to 20 percent of all of the money that the Health Care Finance Administration pays out is in fraudulent claims. Can you imagine that? Fifteen to twenty percent of that money? That is stunning. And what we have done in the Medicare reform proposal that we will be voting on, and I believe passing next week in this Chamber, is we have put together an 11-point program to ferret out for the very first time, to genuinely and honestly and aggressively and with a very tough program, get at waste, fraud and abuse in Medicare, and particularly fraud.

What are we going to do? The first thing we are going to do is make the 35 million beneficiaries, Medicare recipients, we are going to make out of them, we are going to make 35 million watchdogs of the Federal Treasury. And they are going to be given, every single beneficiary will be given a financial incentive to actually look at the bills, to ferret out the mistakes, to find out if it is a bona fide bill or not a bona fide bill.

Every single Member of this Congress, I guarantee you, has been told stories by his or her constituents at home about specific examples of overbilling, weird examples of billing that goes on months after a person has passed away, double billings, billings for procedures that have not been actually performed, billings for procedures that were performed but then were rebilled several days later.

There are more horror stories about the fraud and abuse. You can understand that, when you see that, up to 20 percent of all of the money that is spent on medical costs under Medicare is believed to be fraudulent.

So we have put together, there is going to be a Commission that will specifically look at private sector methods, because I can tell you in the State of Ohio, where I come from, that the Blue Cross/Blue Shield plans in northeastern Ohio realized there was a terrible problem with fraud. They got onto this about 8 or 10 years ago, and they went after the problem. They decided they were going to solve this problem.

What did they do? They contracted with people that ferret out fraud and abuse in the private sector. Think about it for a second. We had a shoplifting problem in this country up until a number of years ago, before the big companies figured out how to get a handle, really get a handle, on shoplifting as an overall problem.

Now we know that, if somebody goes into a place like a K-Mart or a Sears, they are not going to be able to get out of there stealing things. Why not? Because large retailers decided they were going to do something about this problem and they were going to get at it and solve it and were not going to allow it to affect their bottom line and affect the way they do business.

That is exactly what insurance companies have done around the country, and that certainly is what Blue Cross and Blue Shield of northeastern Ohio has done. They have gotten at that problem. That is exactly what we are going to do with respect to Medicare. We are going to get at that problem. The first way that we do it is with making 35 million Medicare recipients watchdogs of the Federal Treasury.

Ms. DELAURO. Mr. Chairman, will the gentleman yield?

Mr. HOKE. I yield to the gentlewoman from Connecticut.

Ms. DELAURO. I thank my colleague for yielding.

I just wanted to address a point. I was in my office doing work and listening at the same time as we all do, and noted your commentary with regard to the trustees and the Medicare Trust Fund. I wanted to take this opportunity.

Mr. HOKE. I would be happy to yield for a question or a comment, not a long speech.

Ms. DELAURO. I will be quick. The point is in fact I think there is some misrepresentation of what the trustees have said. I will quote from the September letter from the trustees addressed to the Speaker and to the majority leader.

The trustees have said, because I know that that is a read on which my colleague has hung his commentary and his colleagues have hung the commentary. And this is a quote from the trustees, from really actually the Secretary of the Treasury, Mr. Bob Rubin, a Wall Street business person before he came to this position. Simply said, no Member of Congress should vote for $270 billion in Medicare cuts believing that reductions of this size have been recommended by the Medicare trustees or that such reductions are needed now to prevent an imminent funding crisis. That would be factually incorrect.

I just might add the trustees in fact did say that $90 billion was more in the nature of what was needed over a period of time to look at the solvency issue. And to that end, in the Committee on Ways and Means this week, our Democratic colleagues offered a specific amendment that talked about a $90 billion savings over the next 7 years to deal with the solvency problem to the year 2006.

That was defeated by the Republicans. The question is, if $90 billion is what the trustees have said is necessary and we want to hang our hat on what the trustees have said, then what happens to the additional $180 billion? You cannot rely on the trustees on the one hand to talk about what they have said that we need to do for the solvency, and then discount what they say when they say it is not $270 billion, but in fact it is $90 billion.

In response to the cry that the Democrats have not had a plan or proposal, in fact and in deed there was an amendment in the Committee on Ways and Means for $90 billion. In addition, a commission was set up that would deal with the longer solvency problem, what has to do with baby boomers, a bipartisan commission set up down the line. That was defeated. You have to represent the entire situation rather than just wanting to use the trustees as it might satisfy your point.

Mr. HOKE. Reclaiming my time, I will respond to that.

Ms. DELAURO. Mr. Speaker, I would like to put in the RECORD the op ed that was written by the trustees in response to this issue and talking about $270 billion being factually incorrect.

[From the Houston Chronicle, Sept. 5, 1995]

IT'S NOT NECESSARY TO CUT MEDICARE BENEFITS

(By Robert E. Rubin, Donna E. Shalala, Robert B. Reich, and Shirley S. Chater)

The United States is involved in a serious examination of the status and future of Medicare. Congressional Republicans have called for $270 billion in cuts over the next seven years, claiming that Medicare is facing a sudden and unprecedented financial crisis that President Clinton has not dealt with, and all of the majority's cuts are necessary to avert it.

While there is a need to address the financial stability of Medicare, the congressional

majority's claims are simply mistaken. As trustees of the Part A Medicare Trust Fund which is the subject of the current debate, and authors of an annual report that regrettably has been used to distort the facts, we would like to set the record straight.

Concerns about the solvency of the Medicare Part A Trust Fund are not new. The solvency of the trust fund is of utmost concern to us all. Each year, the Medicare trustees undertake an examination to determine its short-term and long-term financial health. The most recent report notes that the trust fund is expected to run dry by 2002. While everyone agrees that we must take action to make sure it has adequate resources, the claim that the fund is in a sudden crisis is unfounded.

The Medicare trustees have nine times warned that the trust fund would be insolvent within seven years. On each of those occasions, the sitting president and members of Congress from both political parties took appropriate action to strengthen the fund.

Far from being a sudden crisis, the situation has improved over the past few years. When President Clinton took office in 1993, the Medicare trustees predicted the fund would be exhausted in six years. The president offered a package of reforms to push back that date by three years and the Democrats in Congress passed the plan. In 1994, the president proposed a health reform plan that would have strengthened the fund for an additional five years.

So what has caused some members of Congress to become concerned about the fund? Certainly not the facts in this year's Trustees Report that these members continually cite.

The report found that predictions about the solvency of the fund had improved by a year. The only thing that has really changed is the political needs of those who are hoping to use major Medicare cuts for other purposes.

President Clinton has presented a plan to extend the fund's life. Remarkably, some in Congress have said that the president has no plan to address the Medicare Trust Fund issue. But he most certainly does. Under the president's balanced budget plan, payments from the trust fund would be reduced by $89 billion over the next seven years to ensure that Medicare benefits would be covered through October 2006—11 years from now.

The congressional majority's Medicare cuts are excessive; it is not necessary to cut benefits to ensure the fund's solvency. The congressional majority says that all of its proposed $270 billion in Medicare cuts over seven years are necessary. Certainly, some of those savings would help shore up the fund, just as in the president's plan. But a substantial part of the cuts the Republicans seek—at least $100 billion—would seriously hurt senior citizens without contributing one penny to the fund. None of those savings (taken out of what is called Medicare Part B, which basically covers visits to the doctor) would go to the Part A Trust Fund (which mostly covers hospital stays). As a result, those cuts would not extend the life of the trust fund by one day.

And those Part B cuts would come out of the pockets of Medicare beneficiaries, who might have to pay an average of $1,650 per person or $3,300 per couple more over seven years in premiums alone. Total out-of-pocket costs could increase by an average of $2,825 per person or $5,650 per couple over seven years. According to a new study by the Department of Health and Human Services, these increases would effectively push at least half a million senior citizens into poverty and dramatically increase the healthcare burden on all older and disabled Americans and their families. The president's plan, by contrast, protects Medicare beneficiaries from any new cost increases.

As Medicare trustees, we are responsible for making sure that the program continues to be there for our parents and grandparents as well as for our children and grandchildren.

The president's balanced budget plan shows that we can address the short-term problems without taking thousands of dollars out of peoples' pockets; that would give us a chance to work on a long-term pan to preserve Medicare's financial health as the baby boom generation ages. By doing that, we can preserve the Medicare Trust Fund without losing the trust of older Americans.

Mr. HOKE. I think it is really remarkable that what had been a completely unpoliticized document, that is, the trustees report of April 3, 1995, when that document was actually scrutinized and read with great interest by the American people and by Members of Congress and was used on this floor to bring to the attention of the American people the very calamitous situation that Medicare finds itself in, that that, all of a sudden, the trustees—it is not the trustees, it is one Mr. Robert Rubin who has written this letter claiming that——

Ms. DELAURO. Secretary of the Treasury, Wall Street business person——

Mr. HOKE. Who has written this letter now in a very, very political way. He has decided to jump in politically because he sees that apparently the President's approach to this, which had been, frankly, very evenhanded, which had recognized that, yes, there clearly is a problem with respect to Medicare, Medicare has got to be fixed. We have got to step up to the plate and fix this problem.

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The President apparently has been more recently, in the past month, or even less, 3 or 4 weeks, he has been persuaded by Democrat leadership in the House that political points can be scored by repeating this mantra of slashing Medicare in order to pay for tax cuts for the rich. I think that that is bad politics. It certainly is bad policy, and I am not going to yield more time at this point.

Ms. DELAURO. Mr. Speaker, I thank the gentleman for the time that he did yield.

Mr. HOKE. Mr. Speaker, the gentlewoman is very welcome.

With respect to the $90 billion cuts that were actually suggested by Democrats in the Committee on Ways and Means, I do not know if those were $90 billion scored that way by the CBO or if they would have been scored higher. The fact is the cuts the President talked about of about $135 or $140 billion were scored by CBO at about $190 billion.

The truth is that every reasonable person in this body, every responsible person who has examined the situation, every responsible person in the administration, every person who is looking at it in a dispassionate and temperate way, not for political gain, not for political purposes but for the purposes of preserving, protecting and improving Medicare not just for this generation but also for the next generation, has concluded without question that we have to fix the problem.

We believe that we cannot only fix the problem, that is the impending problem of bankruptcy, but we can offer so much more to senior citizens in terms of what will be available for them under choices that they ought to have as senior citizens that are available to other people in the country as well.

Let us look at, first of all, the managed care option, because I think it is an interesting and a good option. The truth is there will be a lot of senior citizens who will be interested in it because it is going to offer them more care for less money. Let us face it, it will be less expensive for them. At the same time, in order to qualify, they would have to be part of an ''HMO'' or health maintenance organization, a managed care plan.

What does that mean? It means that you go through somebody who decides whether or not you are going to see a physician at a particular time for a particular ailment.

What I have found is that senior citizens who can sign up with an HMO that has, as one of the physician members in the HMO, if the senior citizen's physician is already in the HMO, then that HMO becomes very attractive to the senior citizen. If that senior citizen's physician is not in the HMO, then they are not particularly interested.

It is also apparent that the older the senior citizen, the less attractive any kind of change to an HMO becomes. That is why it is very, very important that senior citizens be reminded by me and by others that the first option that they have with Medicare Plus is to stay in traditional fee-for-service medicine, exactly the way that it is today. If what they opt for is to stay in the Medicare Program, the traditional fee-for-service Medicare Program as it is today, with exactly the same copayments, with exactly the same deductibles, and with exactly the same part B premium, they can do that. That is available to them. They can do that.

What is also to be available to them are a number of other choices that emulate and resemble choices that are available in the private sector to citizens in the United States today. Let us talk about this HMO, because I think it will be an option that will be attractive to some senior citizens.

The reason is that what will happen, I believe, and what can happen under the plan, and what has happened in other States already, where they have piloted this, particularly in Florida, and there are two HMO's in northeastern Ohio, Medicare HMO's, is that, at least in Florida, already you can join a Medicare HMO and you can have full prescription drug coverage. That is

not true under traditional fee-for-service Medicare. But it is true under Medicare HMO's that are being run in Florida right now.

I think it will probably be even more true in the rest of the country when there is a lot more competition. Because if there are 8 or 10 or 12 or 15 HMO's competing for Medicare senior citizens to be in their plan, what you will find is that they will find ways to do it better for less money and they will offer greater services.

But the marketplace will be working and the marketplace will work very aggressively. I think it would be reasonable to assume that there will be plans that will offer complete coverage for prescription drugs, complete coverage for eyewear, complete coverage for chiropractic, and additional coverages for maybe psychiatric or other things that are not covered fully under Medicare today.

Why will that happen? Because the marketplace will be at work, and it will be working to make the delivery of services more efficient.

I have to tell you that personally, from my own personal point of view, HMO's are not the delivery service of choice or delivery system of choice. I think they are decidedly, frankly, un-Republican, in the sense that they are top down. They are driven from the top and are bureaucratic.

I would think they would be much more attractive to my friends and colleagues on the other side of the aisle. In fact, they have been in the past, and it was a big part of what the President was talking about in terms of mandating people to get into in the 1993 health reform that was so soundly rejected by the American public.

In any event, there are HMO's that exist today. A substantial number of American citizens are covered by HMO's in the private sector, and people tend to have varying degrees of satisfaction with them, I suppose. The one that I like is the plan that is a medical savings account, a Medisave account, plus a high dollar catastrophic, high deductible catastrophic insurance policy.

I think this will be tremendously popular with some senior citizens, not all senior citizens. Remember again, this is another option that senior citizens will have. They can stay in traditional fee-for-service medicine, Medicare. They can get into a Medicare HMO, or they could opt for a medical savings account.

Let us talk about what a medical savings account does, because I think there has been a lot of talk about it but not a lot of understanding. Medical savings accounts allow you to purchase catastrophic illness insurance guarding against extraordinary costs and then deposit money into an MSA, a medical savings account, to cover the routine costs. The difference between the MSA level and the insurance policy's deductible would be certainly less than what today's seniors pay for so-called medigap policies.

I will give you an exact example of how this works so it will make more sense to you. Right now we do not really have health insurance in this country, we have more like what is prepaid health care. In other words, we pay on a monthly basis to cover a whole slew of things that we know will go wrong.

It would be as though you were paying on a monthly basis to have your brakes realigned, your oil changed regularly, and your shocks and tires rotated. We know there are certain things that we are going to experience in terms of our needs, our health care needs. But what insurance is supposed to do, real insurance is supposed to protect individuals against unaffordable losses due to unforeseen circumstance. That is what insurance is supposed to do. It is supposed to create a pool of money that allows us to share the risk, the real risk of having unforeseen things happen to us that are calamitous and that we cannot afford.

That is what insurance is supposed to do. Specifically, what it really does is it allows you to sleep at night so that you know if you have some problem you cannot get wiped out as a result of that.

Well, what the Medisave plan does is it goes back to the real theory, the underlying theory of insurance with a high deductible policy. Let us say that the first $3,000 is the amount of the deductible. It would be like if you had a car insurance policy where the first $3,000 of damages would have to come out of pocket. Instead of having to come out pocket, that first $3,000 would be in a Medisave account.

Where does the money come from? Well, let us go back to how much we are spending right now per beneficiary per year. We are spending $4,800; the Federal Treasury, through the Medicare trust fund, is spending $4,800 per beneficiary per year. That money, that $4,800 would be divided up between a medical savings account, money placed in a medical savings account, or buying a high deductible insurance policy.

The money that is in the medical savings account, plus money that the beneficiary, him or herself, could put in that account. Presumably, that would be the money that a senior citizen is now paying for medigap insurance. Most senior citizens buy medigap insurance to cover the amount that is not covered by Medicare, that money they could use in that medical savings account up to the amount of the deductible.

Now, if they use it, that is great. If they need it, that is great. It gets used up, and then after that, the insurance company takes over. If they do not, at the end of the year, who does that money belong to? Does it belong to the insurance company? No. Does it go back to the Government? No. It belongs to the senior citizen. What is the point of all this? The point of this is to give incentives to the individual who is getting the care. The point is to actually create consumer motivation on the part of the patient, the beneficiary, the Medicare beneficiary.

What does it mean? It means that that beneficiary is going to be making the same kind of cost conscious consumer decisions in the purchase of their health care that they make in every other area of their lives, whether it has to do with housing, or whether it has to do with clothing, whether it has to do with food. And they are going to become cost-conscious consumers of health care as well.

Now, a lot of people say, well, that is ridiculous; that is not the way it works. People do not make good decisions with respect to health care based on cost. I will give you a couple of examples of things that have to do with health care where people do and where it has been extraordinarily successful.

First of all, and I know that this will, Mr. Speaker, apply to many, many people who hear this, it has to do with eyewear. The fact is that eyewear is not something covered either by Medicare or, by and large, by private insurance. What have we seen in the area of eyewear where we do not have third party payers but in fact we have consumers purchasing the product? What we see is the following: You can get your eyes checked and you can have your eyes examined by any of three different people with levels of education and expertise. You can go to an optometrist, an optician, or an ophthalmologist at different levels of education and expertise and different costs. You can go to any mall in this country and actually have your eyes checked and a prescription filled the same day. So there is tremendous consumer availability.

Not only that, but we have seen the prices of glasses on an inflation-adjusted basis remain flat for the past 25, 30 years. We have seen the prices of contact lenses come down dramatically over the same period of time. So, clearly, consumer forces work in the medical area.

They also work with respect to dental services, which are largely not paid for by insurance companies. They even work in the area of pharmaceutical supplies and prescription drugs, which also are in many cases not covered by insurance. They are not covered by traditional fee-for-service Medicare, although they are covered in some Medicare HMO plans.

What does this mean? It means that you have seen the proliferation of generic drugs and of discount programs and drugs by mail, and the market has responded to bring those prices down. There are other things that push drug prices up, such as liability issues and the difficulty of getting drugs to market in this country because of FDA hurdles that are overwrought and too high. But, in any event, the point is that consumer forces can work in the health care area, and medical savings accounts will offer senior citizens the

opportunity to make choices themselves, manage their own health care, and actually become the drivers and be in the driver's seat when it comes to making health care choices. So that is another choice.

The point of this is the plan that we are going to vote on next week is going to do a number of important things. No. 1, is will take us out of the 1960's with respect to the delivery of health care to senior citizens. It will preserve the traditional fee-for-service Medicare for seniors that want it, but it will also give them a number of other choices, including managed care plans, including medical savings accounts, including some other things that I have not discussed with you that are a little bit more complex. But it will give a range of choices that will be available.

What will it do with respect to the spending? It will increase the spending from $4,800 per year to $6,700 per year. What does that mean over that period of time? It means we are going to spend twice as much on Medicare in the next 7 years than we have spent in the previous 7 years. It also means that we are going to increase the spending on an annual basis of about 6.5 percent per year. In other words, we are increasing 6.5 percent per year on average from 1995 to 2002.

What are we doing right now in the private sector? Well, in 1994, a big six accounting company report came out and said that the increase in the inflation in the health care sector is now down to about 3.1 percent in the private sector. Think about that for a second. Why has it gone down to 3.1 percent? The reason that it has gone down to 3.1 percent is that America has woken up. Individuals, families, companies, employers, they have said we are not going to allow this to continue, this kind of double-digit health care inflation. We have had it. We are going to do what is necessary to squeeze all the fat out of the delivery of health care in this country. We are going to fix the problem. That is exactly what the private sector has done.

What was it that CBO had projected the increase to be at which gives the Democrats, my friends on the other side of the aisle, the ability to claim this $270 billion cut, which does not exist, of course? Well, what was the projection by CBO? They projected we would be increasing at 10.5 percent per year over the next 7 years.

We are saying we are going to increase at 6.5 percent per year. But either way, what has made it possible? Why is it that we have gone up at 10.5 percent per year in the public sector, with government funding of health care, but we are now only going up at 3.1 percent in the private sector? The fact is that it goes up at 10.5 percent per year because it can, because we have allowed it to, because we have said that is what the amount is going to be. We have made it an entitlement, and nature abhors a vacuum. so the amount of spending will certainly fill the amount that is appropriated. It is absolutely guaranteed that will happen.

My own prediction about what will happen with respect to the Medicare reforms is that we will not need the 6.5-percent increase. We will not use that much money because these other factors will come into play and will actually use market forces to squeeze out the waste, fraud, and abuse, to squeeze out the fat, to squeeze out and bring about market competitive forces into play.

So that is what we will be dealing with next week on the floor. I think, Mr. Speaker, the American people deserve to know the facts about this and that, the more that they learn about Medicare, the more that they see exactly what choices will be available to them, the expansion of the choices, the more that they will absolutely and utterly reject the scare mongering, what the Washington Post called medagoguery that has been taking place on the other side of the aisle. And I think it is to the discredit of the President of the United States that, while he had, up until the past 2 or 3 weeks, been, very frankly, evenhanded and accurate in his rhetoric about the problems with Medicare and the need to fix those problems, he has now dived into the same muck bucket that my friends on the other side of the aisle have been engaged in all year by making this a political issue and politicizing it rather than making it a policy issue that deserve everybody's attention and that they should join us to try to come up with solutions that will be real.

This letter that Bob Rubin, the Secretary of the Treasury, has decided to send now, which is blatantly political, that letter is clearly an example of this decision that was probably made in consultation with pollsters, handlers, and political consultants to go political on the course instead of to talk about it in a dispassionate, rational way so that this program that is so important to American senior citizens could be preserved. Instead, what you get now is a great deal of scare mongering and the attempt to create anxiety on the part of senior citizens.

I know that, Mr. Speaker, they are not going to believe it. I know that they know that we have parents who are on Medicare ourselves and that we feel the responsibility that responsible legislators everywhere in this country feel, and that is to do what is right to preserve this program that has been a great success for the American people.

With that, Mr. Speaker, I will yield back the balance of my time.

REPUBLICANS RUSHING MEDICARE REFORM LEGISLATION

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from New Jersey [Mr. PALLONE] is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, I probably will not use all the hour, but I will ask for at least that initially.

I wanted to come because of the developments that have occurred in the last few weeks particularly this week with regard to Medicare and the Republican leadership proposal to change Medicare.

I happen to be a member of the House Committee on Commerce. The Committee on Commerce spent this past Monday and Tuesday doing a markup of the Medicare bill and did report the bill out on Tuesday late in the evening. I am very concerned about that bill. I understand it may be coming to the floor sometime next week, perhaps as early as next Thursday.

I think it is a terrible thing that this legislation is coming to the floor of the House of Representatives without ample opportunity for hearings and sufficient debate.

As I have mentioned before on the floor of this House, Mr. Speaker, our Committee on Commerce did not have hearings on the legislation. In fact, a substitute bill, which was actually the bill that we voted on just this past week, we only received about 24 hours before the time we were actually asked in committee to mark up the bill. So what, in effect, the Republican majority is doing is rushing Congress into these Medicare changes without most of us even knowing what the changes are and what the implications are going to be on America's seniors.

Just to illustrate that point, I wanted to start out, Mr. Speaker, by entering into the RECORD, ands I think part of it may already be in the RECORD, but I wanted to mention some highlights of an editorial that was in my hometown newspaper, the Asbury Park Press, on Tuesday, October 10. And if I could just highlight some of the statements that were made in the editorial, it is captioned ''Explain The Changes'':

Congress should not be rushing on Medicare. The editorial starts out by saying that congressional Republicans are moving too fast on reforming Medicare, the Federal health insurance program for the elderly. They propose to squeeze $270 billion from Medicare spending over the next 7 years, about a 14-percent reduction. And, as they did in their first 100 days, the Republicans plan to speed up the voting on their Medicare spending bills without taking much time for floor debate.

Given their importance, the revolutionary changes the Republicans propose are worth at least as much time and attention as they have given to, say, the Whitewater affair. As it stands, two House committees plan to complete action on the Medicare changes by tomorrow night. That was earlier this week, just 2 days after revised versions of the bill were distributed to committee members. And again, that is exactly what we did.

Under one major GOP proposal to save money, senior citizens would be